REMARKS BY REPRESENTATIVE HENRY A. WAXMAN

to the

NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

MAY 16, 1994

Thank you for inviting me. It's a pleasure to have the chance to talk with you about our efforts to advance health reform, and how you can help us with this important work.

It's been about 16 months since President Clinton first announced his intention to achieve universal coverage for all Americans.

It's been about 6 months since the President's Health Security Act was introduced.

And we have about 6 months left in this Congress to act on the President's proposal.

This is an historic opportunity to reform the nation's health care system. We cannot afford to let the opportunity slip away.

But unless all Americans become more forceful in advocating for reform, we may lose this opportunity. Because the opposition to health care reform is savvy, well-financed, and determined, a strong constituency for reform will be needed to overcome it.

I am a cosponsor of the President's plan. It's not my first choice. But it has the basic features of true health reform -- and, with a lot of work by institutions like yours, it can pass.

-- It guarantees universal coverage by January 1, 1998.

-- It provides a comprehensive benefit package.

-- It limits the rate of increase in health care costs.

-- It preserves and enhances consumer choice.

I would guess that a number of you -- like me -- are uncomfortable with particular pieces of the President's proposal. However, I would urge you to consider what our health care system will look like in 1998 or 2000 if we do nothing this year.

-- The number of uninsured Americans will increase.

-- The number of underinsured Americans will increase.

-- The costs of health care will continue to increase at rates well in excess of the rate of increase in wages.

-- Medicare and Medicaid payments to providers will be cut back substantially -- and maybe even capped -- to help reduce the Federal deficit. AND

-- Managed care plans will continue to market aggressively to all of the healthy patients while avoiding contracts with higher-cost hospitals and their sicker patients.

In short, left to their own devices, problems in the health care system will get worse, not better.

Some of my colleagues in the Congress are urging incremental changes such as:

-- rules to prevent risk-selection in the sale of health insurance products to small groups;

-- developing more community health centers to serve urban and rural underserved areas;

-- simplifying and standardizing billing forms;

-- limiting the amount of recovery available to victims of malpractice.

I think the proponents of this incremental approach are wrong. Without universal coverage and cost containment, these types of changes will simply make matters worse.

Premiums for small group insurance will go up at an even faster rate, leading more employers that now offer coverage to cut back on it or drop it altogether.

And the community health centers will never be able to keep up with the demand for services by the rapidly growing number of uninsured.

Prospects in the Energy and Commerce Committee

Let me say a few words about the status of health reform efforts in the Energy and Commerce Committee.

In my Health and Environment Subcommittee, we held 24 hearings between November and February in order to prepare members for mark-up of the President's bill. However, two months ago, Mr. Dingell, the Chairman of the full Committee, and I decided to bypass the Subcommittee in order to maximize the chances of reporting a strong bill from the full Committee.

Of the 44 members of the full Energy and Commerce Committee, 27 are Democrats. With all 17 Republicans adamantly opposed to the President's bill or any other version of universal coverage, Mr. Dingell needs the support of 23 Democrats to send legislation to the Rules Committee and then the House floor.

You need to know that a majority of the Democrats in our Committee will insist on a bill that does not increase the deficit. That's quite a challenge since the Congressional Budget Office found the President's bill would add some $74 billion to the federal deficit over the next five years.

So, our first task has been to make revisions in the President's bill that eliminate this shortfall, and hopefully to find additional revenues or savings to support improvements and reductions in the large amount of Medicare cuts proposed in the President's plan.

Chairman Dingell and his staff have worked extremely hard over the past two months to line up the necessary votes for the President's bill. He has proposed a number of changes in the President's plan in order to address Member concerns and the deficit problem:

-- No mandatory alliances.

-- A reduced benefit package.

-- Exemption from the mandate to provide coverage for all employers with 20 or fewer employees.

-- Elimination of the Breakthrough Drug Review Board.

Despite these concessions, the Chairman has still not been able to assemble a working majority, and he has not set a date for markup. He, I, and the other Democrats on the Committee that want universal coverage are now in the process of reviewing our options. No one wants to enact universal coverage more than Chairman Dingell and myself.

Status in Other Committees

In the meantime, Chairman Stark's Ways and Means Health Subcommittee has already reported out a bill, and Chairman Pat Williams' Education and Labor Subcommittee is in the process of doing so. Hopefully, both of those full Committees will be able to report legislation by the end of this month. If we are to succeed, the House must take up health care reform this summer.

I think most of us can agree that we have a rare opportunity before us. Two forces are converging that -- in my view -- make health reform not only necessary, but possible.

First, we have a growing public recognition that current conditions in our health system left unattended are self-destructive -- threatening not only the poor, but all Americans. This awareness offers the opportunity to gain broad support for comprehensive health reform.

Second, we have a President and a First Lady who understand the problems we face, and who have provided the kind of sustained leadership that is required to reach consensus on a what is certainly one of the most challenging legislative initiatives ever undertaken.

If we can stick to the fundamental principles of universal coverage, progressive financing, consumer choice, and cost containment, I believe the American people will embrace reform.

But we must not give the naysayers -- the defenders of the status quo -- the opportunity to pick a comprehensive plan to pieces.

PRESCRIPTION DRUG BENEFIT

I know that you are particularly interested in the prescription drug benefit, and so I would now like to turn to the key issues pertaining to the provision of prescription drugs under the President's plan.

For many years, I have been extremely concerned about rising prescription drug prices, which have the effect of denying medical care to many people. Hearings held by my Subcommittee have demonstrated that Americans pay far more for prescription drugs than citizens in other countries. We have also found that the prescription drug companies in general are far more profitable than companies in other industries that involve comparable risk. Finally, in recent years prescription drug prices have risen much faster than the Consumer Price Index or other segments of the health care system.

I am also a strong supporter of medical research. For that reason, I sponsored the Orphan Drug Act which created incentives to develop drugs that are designed to treat rare diseases, and yet had no patents. I also authored the 1984 law which both opened the door to the approval of generic drugs and gave research companies patent extensions to compensate for time taken for regulatory review of their products.

In recent years, there are two extremely encouraging developments that will both moderate drug prices and shift research dollars to important breakthrough drugs. The first is the wider availability of generic drugs. Today generic drugs are injecting competition into the sale of prescription drugs. They are saving consumers and the federal government hundreds of millions of dollars.

The second important development is the increasing use of formularies by hospitals, HMOs and managed care benefit plans. Institutions that use these formularies are able to use price considerations to chose among therapeutically equivalent drugs, and to use their market power to negotiate price discounts with drug manufacturers. As a result, research on "me too" drugs -- patented drugs that offer no advantage over products already on the market -- will yield lower profits. This will encourage drug manufacturers to allocate more of their research dollars to developing breakthrough drugs.

The Health Security Act correctly starts with the principle that we should use competition to control prescription drug prices where competition will work. The plan will encourage the use of generic drugs and formularies, which under the Clinton Plan should continue to have an extremely important impact on moderating drug prices.

There are three places where market forces can not be expected to work to control prescription drug prices, and where we must devise an approach that balances the need to contain prices and the need to maintain incentives to encourage research on prescription drugs.

The first is breakthrough drugs. Formularies work only where more than one drug has been approved to treat a particular disease or condition. By definition breakthrough drugs have no me too equivalents and they have no generics.

In recent years we have seen an increasing number of breakthrough drugs priced at $10,000 per year or more. While these seem like outrageous prices, I suppose that the fact that most $10,000 per year prescription drugs are paid for by private insurance is something of a constraint on prices. If the prices get too high, there is always the possibly that insurance companies will write their policies so they don't have to reimburse for these drugs.

Under national heath care, access to breakthrough drugs will be guaranteed. In theory, the drug companies can charge whatever price they want, and as long as they have a unique product, their market will be guaranteed.

Unfortunately it is very difficult to figure out how to regulate the prices of breakthrough drugs without jeopardizing the incentives needed to finance the research needed to discover them. The drafters of the Clinton Plan were so skittish about this that they decided only to establish a breakthrough drug committee whose sole authority would be to issue reports stating that the price of a breakthrough drug is too high. Even so there is tremendous opposition to even this minimal approach.

In my opinion, it will be very unfortunate if national health care is enacted without any check whatsoever on the prices of breakthrough drugs. It seems to me that there is absolutely no evidence that current incentives are insufficient to stimulate research on breakthrough drugs. Yet the effect of the Clinton bill will be to make the sale of breakthrough drugs even more profitable if we guarantee a market for these products without any mechanism to control prices.

The second area where market mechanisms do not work is the Medicare drug benefit. In theory, the Clinton Plan could have permitted Medicare to use a national formulary to save money by selecting among me-too drugs on the basis of price. But the Health Security Act did not chose that approach. Instead it guarantees Medicare recipients any drug prescribed by a physician, unless the Secretary of HHS decides that a new drug is too expensive and is unable to negotiate a special rebate from the manufacturer.

The drug companies argue that the Secretary's ability to negotiate a rebate is tantamount to price controls because the Secretary may remove a drug from Medicare coverage if he or she thinks that its price is unreasonable. I would urge those who make this argument to look at the alternative. Is it responsible to tell the Secretary of HHS that we will purchase drugs, breakthrough and me too drugs, regardless of the price?

Does this mean that a drug company can gain permission to market a me too-drug -- that is a drug that is no better than drugs that are already on the market -- and set the price at ten times the price of drugs already available? Does it mean that the federal government must pay for that drug if the company can convince a physician to prescribe it? I understand why the drug companies argue for this result, but it doesn't seem to me that a responsible approach to national health care can accept it.

The third area where the market doesn't work is one that I know is near and dear to the hearts of everyone in this room -- and that is the retail segment of the market. There is strong evidence that in recent years the drug companies have made up for the price discounts that competition has forced them to give to formularies by cost shifting to the prescription drug retailers. Retailers can not take advantage of drug formularies because they must stock every drug a physician might prescribe.

As a result, retail drug prices have soared out of control. This is particularly troubling for the obvious reason that many retail prescription drug purchases are not covered by insurance. A significant number of elderly people use a large proportion of their incomes to pay for prescription drugs.

Even under national health care, the retail cost of prescription drugs have a direct impact on consumers who will pay the $250 deductible in the prescription drug benefit. Each year, many people will not benefit from the prescription drug benefit because their prescription drug costs will be less than $250. Retail prices will also have an obvious impact on the federal budget and on the premium that medicare recipients must pay in order to receive the benefit.

The President's bill would address this issue with a provision that requires that companies charge the same price to purchasers who purchase drugs on the same terms and who are in the same position. It is my understanding that this provision would do little more than enforce principles of existing law -- namely the Robinson Patman Act -- which prohibits price discrimination.

I believe that this issue needs to be studied very carefully. We need to look at the language in the President's bill to determine whether it would actually address the problem of discriminatory pricing.

There is stronger language that has been proposed that would insure that retailers and formularies get access to the same price discounts. We need to look at that language as well. I want this problem addressed, but I certainly don't want to go down a road where all discounts are eliminated -- where everybody is required to pay the retail price. I also want to look at proposals to make all drug prices public and to consider whether these proposals would address the serious price discrimination between retail and institutional drug prices.

Conclusion

As difficult and contentious as health reform will certainly be, if we fail to act, we will continue on a course that is certain to result in the collapse of our insurance system, unacceptable financial burdens on businesses and workers, and a dramatic decline in the quality of our lives.

Obviously, the stakes are high. Despite all of the problems and shortcomings of our current system, reaching agreement on the elements of a new system will not be easy. However, I think we can all agree that basic health services must be covered for all Americans, that care must meet appropriate quality standards, and that coverage must be secure and affordable.

Thank you for the invitation to join you today. We have a lot of work ahead of us and I look forward to our continued collaboration.